Emflaza
Prior Authorization Form

Fax completed form to:
855-207-0250
For questions regarding this prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that members receiving a new prescription for Emflaza must meet the criteria for use available at www.hidesigns.com/assets/files/ndmedicaid/NDPDL.pdf

Part I: TO BE COMPLETED BY PRESCRIBER REPRESENTATIVE

Member Name	Member Date of Birth	Member Medicaid ID Number
Prescriber Name	Specialist involved in therapy (if not treating prescriber)	
Prescriber NPI	Telephone Number	Fax Number
Requested Drug and Dosage:	**Diagnosis for this request:**	
List all failed medications:	**Start Date:**	**End Date:**
• **Member's serum creatinine kinase activity prior to initiating treatment:**		
• **Member's current motor milestone score** (provide score and assessment used):		
• **Did the member experience onset of weakness before 5 years of age?**		☐ YES ☐ NO

INITIAL: **Member has experienced the following significant intolerable adverse effects*** (select all that apply)
- ☐ Cushingoid appearance
- ☐ Central (truncal) obesity
- ☐ Severe behavioral adverse effect
- ☐ Undesirable weight gain (>10% of body weight gain increase over 6-month period)
- ☐ Diabetes and/or hypertension that is difficult to manage

• *RENEWAL*: **Member has experienced an improvement from adverse effects experienced on prednisone***	☐ YES ☐ NO

Documentation of experienced adverse events or improvement on Emflaza must be provided with this request

☐ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the member.*

Prescriber (or Staff) / Pharmacy Signature**	Date

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the member's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #